STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155150	A. BUILDING _____ B. WING _____	01/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	640 WEST ELLSWORTH ST COLUMBIA CITY, IN 46725

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. Survey dates: January 17, 18, 19, 20 & 21, 2011 Facility number: 000071 Provider number: 155150 Aim number: 100273140 Survey team: Angela Strass, RN- TC (January 17, 18, 20 & 21, 2011) Julie Wagoner, RN (January 17, 18, 19 & 20, 2011) Tim Long, RN (January 17, 18 19 & 20, 2011) Census bed type: SNF: 9 SNF/NF: 52 Total: 61 app 2/16/11 BM Census payor type: Medicare: 6 Medicaid: 38 Other: 17 Total 61 Sample: 15 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on January 16, 2011 by Bev Faulkner, RN	F 000	RECEIVED FEB 11 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH Delete F157 2/16/11 BM	
F 157 SS=D delete BM	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;	F 157	**F157 483.10(b)(11), 410 IAC 16.2, 3.1-5(a)(3).** It is the facility's policy to notify the resident's physician of any changes in condition that may or may not warrant a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Stephen C Ball | ADMINISTRATOR | 2/10/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to notify the physician of numerous medication refusals for 1 of 15 residents reviewed for physician notification (#50) in a sample of 15. delete Findings include:	F 157	change in the treatment plan. It is also the policy of the facility to provide services for all residents to ensure that they receive and maintain the highest practicable quality of care by qualified well-trained staff in accordance with the resident's written plan of care. Resident #50's physician was notified of the resident's medication refusal's immediately when the concern was voiced by the surveyor on 1/20/11. The physician ordered an electrolyte panel to be completed. On 1/20/11, the lab work was obtained and taken to the lab for analysis. The results were received the morning of 1/21/11, and showed that Resident #50's potassium level was at 4.0, which is within the reference range and is an improvement over the prior labs results dated on 9/29/10. A copy of the lab results from 1/21/11 and 9/29/10 were provided to the surveyors during the survey. Each resident's medication record was reviewed by the Director of Nursing on 1/24/11 to check for medication refusals. If the resident had a medication refusal, their physician was notified. All resident's identified had appropriate revisions made to their written plan of care. The Director of Nursing revised the policy for medication refusal to state upon three (3) consecutive refusals of medications, the physician must be made aware of the refusal which will then be documented in the resident's medical record (Please see Attachment N-1). If there are further occurrences of medication refusal for three (3) additional consecutive days, the physician will	1/24/11

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F 157	Continued From page 2 Resident #50's clinical record was reviewed on 1/20/11 at 10:00 A.M. The record indicated the resident was admitted to the facility on 8/19/10 with diagnoses including, but not limited to, Dementia with behavioral disturbances. Review of the resident's MAR (Medication Administration Record) indicated in November and December 2010 and January 1-20, 2011, the resident refused some or all of her medications on 105 medication passes: November 2010: 6:00 A.M.: acetaminophen-codeine elixir 120 mg/5 ml (milliliter), 12.5 mg/5 ml, give 10 ml, refused x 12 (11/6; 11/7; 11/8; 11/9; 11/10; 11/11; 11/12; 11/13; 11/14; 11/26; 11/27; 11/28; 11/30/10); 8:00 A.M.: All medications refused on 11/1/10: Furosemide 40 mg refused x 1; Docusate 100 mg refused x 1; Polyethylene Glycol powder, 17 gm (grams), refused x 1; Potassium Chloride 10 mg refused x 1; Risperidone 0.5 mg refused x 1; Aspirin 81 mg refused x 1; Carbidopa/Levodopa 10/100 mg refused x 1; 4:00 P.M.: Carbidopa/Levodopa 10/100 mg refused x 13; Tramadol HCL 50 mg, 2 tabs, refused x 13 (11/2; 11/3; 11/4; 11/5; 11/8; 11/12; 11/17; 11/18; 11/22; 11/23; 11/26; 11/28/10); 8:00 P.M.: Mirtazepine 15 mg refused x 14; Vitamin D 1000 units refused x 14; Potassium Chloride 10 mg refused x 14 (11/2; 11/3; 11/4; 11/5; 11/8; 11/12; 11/14; 11/17; 11/18; 11/19; 11/22; 11/23; 11/26; 11/27). December 2010:	F 157	be contacted and requested to visit the resident and/or provide additional medical treatment. The Director of Nursing also revised the Admission Audit Form (Please see Attachment N-2) to include labs ordered according to the medication regime and the resident's diagnosis. As a clarification, the comment on page 5 stating that an interview with the Director of Nursing on 1/21/11 at 11:00 a.m. indicated that Resident #50's physician was notified on each of the medication refusals is not accurate. Rather the Director of Nursing stated that the physician had been notified of the resident's pattern of refusing medications upon the physician's monthly routine visits to the facility. Upon providing this notification, the physician did not think that Resident #50's condition had displayed a decline or change that would require any changes in the treatment plan, as was stated in the physician's letter dated 1/20/11. This letter was also provided to the surveyors during the survey. On 2/1/11, all licensed nurses and Q.M.A.'s were inserviced by the Director of Nursing on the revised medication refusal policy (Please see Attachment N-3-1, N-3-2, and N-3-3). It will be the responsibility of the Director of Nursing or her designee to monitor medication records to ensure that all procedures are followed according to the medication refusal policy. This will be conducted through the facility's Quality Assurance Program. The Director of Nursing or designee will complete the Medication Administration/Treatment Administration Review Q/A tool weekly for	

delete

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F 157	Continued From page 3 6:00 A.M.: acetaminophen-codeine elixir 120 mg/5 ml (milliliter), 12.5 mg/5 ml, give 10 ml, refused x 9 (12/2; 12/4 through 12/11/10); 8:00 A.M.: Aspirin 81 mg refused x 4; Carbidopa/Levodopa 10/100 mg refused x 4; Polyethylene Glycol powder, 17 gm (grams), refused x 4; Potassium Chloride 10 mg refused x 4; Risperidone 0.5 mg refused x 4; Risperidone 0.25 mg refused x 4 (12/12; 12/15; 12/30; 12/31); 12:00 P.M.: Carbidopa/Levodopa 10/100 mg refused x 3 (12/15; 12/22; 12/26/10); 4:00 P.M.: Carbidopa/Levodopa 10/100 mg refused x 19; Tramadol HCL 50 mg, 2 tabs, refused x 19 (12/2; 12/4; 12/7; 12/9; 12/12; 12/13; 12/14; 12/15; 12/16; 12/17; 12/18; 12/19; 12/21; 12/22; 12/25; 12/26; 12/28; 12/30; 12/31/10); 8:00 P.M.: Mirtazapine 15 mg refused x 19; Vitamin D 1000 units refused x 19; Potassium Chloride 10 mg refused x 19 (12/2; 12/4; 12/7; 12/9; 12/12; 12/13; 12/14; 12/15; 12/16; 12/17; 12/18; 12/19; 12/21; 12/22; 12/25; 12/26; 12/28; 12/30; 12/31/10). delete January 2011, 1-20: 11:00 A.M.: Carbidopa/Levodopa 10/100 mg refused x 2 (1/8; 1/19/11); 4:00 P.M.: Carbidopa/Levodopa 10/100 mg refused x 4; Tramadol HCL 50 mg, 2 tabs, refused x 4 (1/3; 1/9; 1/14; 1/18); 8:00 P.M.: Mirtazepine 15 mg refused x 5; Vitamin D 1000 units refused x 5; Potassium Chloride 10 mg refused x 4 (1/3; 1/9; 1/13;1/18; 1/19/11) .	F 157	four (4) weeks, and then monthly thereafter to ensure ongoing compliance. Any identified trends will be logged on the Q/A Summary Log and reviewed in the monthly Q/A Meeting. The facility submits this information as credible allegations of compliance.	2/1/11 2/1/11

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F 157	Continued From page 4 Review of the nurse's progress notes indicated no notification of the physician regarding medication refusals in November 2010, December 2010 or January 2011. A physician progress note on 12/11/10 indicated a physician's order was given to discontinue Tylenol elixir due to consistent refusals by the resident to take the medication. An interview with the Director of Nursing (DN) on 1/20/11 at 2:25 P.M. indicated the physician looks at the MARs during his routine visits when he reviews and signs the monthly physician's order's rewrites. An interview with the DN on 1/21/11 at 11:00 A.M., indicated the physician was notified by nursing on each of the medication refusals. delete A facility policy titled: "Medication Refusal," dated 9/1/2004, indicated "If a resident refuses administration of a medication the physician will be made aware of the refusal"; "If the medication refusal has the likelihood of causing significant discomfort or jeopardizes his/her health and safety, the physician will be contacted and emergent interventions will be implemented as directed. Determining significance of a medication refusal is a matter of professional judgement as indicated by the attending physician." 3.1-5(a)(3)	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	**F279 483.20(d), 483.20(k)(1) 410 IAC 16.2, 3.1-35(a), 3.1-35(b)(1).** It is the facility's policy to use the results of comprehensive assessments to develop, implement, review, and revise the resident's health care plan to ensure that objectives and timetables are measurable in order to meet the resident's	

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F 279	Continued From page 5 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop a health care plan for consistent medication refusals for 1 of 15 residents reviewed for health care plan development (Resident #50) in a sample of 15. Findings include: During observation of a medication pass on 1/19/11 at 11:30 A.M., Resident # 50 received her ordered medication, Carbidopa/Levodopa 10/100 mg crushed in applesauce. The resident took one bite, approximately 2/3 of the applesauce with the medication and refused to take the other bite. After several attempts, LPN #3 gave the resident the spoon with the applesauce and medication and the resident flipped the applesauce and medication off the spoon onto the floor. LPN #3 indicated the	F 279	medical, nursing, and mental and psychosocial needs to provide the highest quality care. On 1/19/11, a health care plan for medication refusals was initiated for Resident #50 and provided to the surveyors during the survey. Each resident's medication record was reviewed by the Director of Nursing on 1/24/11 to check for medication refusals. If the resident had a medication refusal, their physician was notified. All resident's identified had appropriate revisions made to their written plan of care. It will be the responsibility of the Director of Nursing or her designee to monitor medication records to ensure that all procedures are followed according to the medication refusal policy and to ensure that medication refusals are included in the resident's written plan of care. This will be conducted through the facility's Quality Assurance Program. The Director of Nursing or designee will complete the Health Care Plan Review Q/A tool on ten percent (10%) of residents weekly for four (4) weeks, and then monthly thereafter to ensure ongoing compliance. Any identified trends will be logged on the Q/A Summary Log and reviewed in the monthly Q/A Meeting. The facility submits this information as credible allegations of compliance.	1/24/11 1/24/11 1/24/11

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F 279	Continued From page 6 resident often refused her medications. Resident # 50's clinical record was reviewed on 1/20/11 at 10:00 A.M. The record indicated the resident was admitted to the facility on 8/19/10 with diagnoses including, but not limited to, Dementia with behavioral disturbances. Review of the resident's MAR (medication administration record) indicated in November and December 2010 and January 1-20, 2011, the resident refused some or all of her medications on 104 medication passes: November 2010: 6:00 A.M.: acetaminophen-codeine elixir 120 mg/5 ml (milliliter), 12.5 mg/5 ml, give 10 ml, refused x 12. 8:00 A.M.: Furosemide 40 mg refused x 1; Docusate 100 mg refused x 1; Polyethylene Glycol powder, 17 gm (grams), refused x 1; Potassium Chloride 10 mg refused x 1; Risperidone 0.5 mg refused x 1; Aspirin 81 mg refused x 1; Carbidopa/Levodopa 10/100 mg refused x 1. 4:00 P.M.: Carbidopa/Levodopa 10/100 mg refused x 11; Tramadol HCL 50 mg, 2 tabs, refused x 11. 8:00 P.M.: Mirtazepine 15 mg refused x 14; Vitamin D 1000 units refused x 14; Potassium Chloride 10 mg refused x 14. December 2010: 6:00 A.M.: acetaminophen-codeine elixir 120 mg/5 ml (milliliter), 12.5 mg/5 ml, give 10 ml, refused x 9.	F 279		

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F 279	Continued From page 7 8:00 A.M.: Aspirin 81 mg refused x 4; Carbidopa/Levodopa 10/100 mg refused x 4; Polyethylene Glycol powder, 17 gm (grams), refused x 4; Potassium Chloride 10 mg refused x 4; Risperidone 0.5 mg refused x 4; Risperidone 0.25 mg refused x 4. 12:00 P.M.: Carbidopa/Levodopa 10/100 mg refused x 3. 4:00 P.M.: Carbidopa/Levodopa 10/100 mg refused x 19; Tramadol HCL 50 mg, 2 tabs, refused x 19. 8:00 P.M.: Mirtazepine 15 mg refused x 19; Vitamin D 1000 units refused x 19; Potassium Chloride 10 mg refused x 19. January 2011, 1-20: 11:00 A.M.: Carbidopa/Levodopa 10/100 mg refused x 2. 4:00 P.M.: Carbidopa/Levodopa 10/100 mg refused x 4; Tramadol HCL 50 mg, 2 tabs, refused x 4. 8:00 P.M.: Mirtazepine 15 mg refused x 4; Vitamin D 1000 units refused x 4; Potassium Chloride 10 mg refused x 4. Review of the resident's health care plans indicated the facility had no health care plan for medication refusals until 1/20/11. An interview with the Director of Nursing on 1/20/11 at 1:40 P.M., indicated a health care plan for medication refusals was initiated on 1/19/11 after LPN #3 indicated the resident refused her medication during observation of med pass by the	F 279		

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F 279	Continued From page 8 surveyor on 1/19/11. 3.1-35(a) 3.1-35(b)(1)	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based of record review and interview, the facility failed to ensure a diuretic medication was adequately monitor for potential side effects for 1 of 6 residents reviewed for unnecessary	F 329	**F329 483.25(l), 410 IAC 16.2, 3.1-48(a)(3).** It is the policy of the facility to ensure that all resident's drug regimen's are free of unnecessary drugs. This includes, but is not limited to, ensuring that the drug regimen is adequately monitored. Resident #50's physician was notified of the resident's diuretic medication refusal immediately when the concern was voiced by the surveyor on 1/20/11. On 1/20/11, an order was obtained from Resident #50's physician for an electrolytes laboratory test and those results were received on 1/21/11. The results showed that Resident #50's potassium was at 4.0, which is within the reference range and is an improvement over the prior laboratory test that was completed on 9/29/10. The results of these lab tests were provided to the surveyors during the survey. Please note that Resident #50 has not displayed any complications, side effects, or adverse consequences between the dates of the two (2) laboratory tests, nor at any other time regarding her diuretic medication. Upon providing this notification to the resident's physician, the physician did not think that Resident #50's condition had displayed a decline or change that would require any changes in the treatment plan, as was stated in the physician's letter dated 1/20/11. This letter was also provided to the surveyors during the survey. All resident's medication records were reviewed. Those residents receiving diuretic	

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F 329	Continued From page 9 medications (#50) in a sample of 15. Findings include: Resident # 50's clinical record was reviewed on 1/20/10 at 10:00 A.M. The record indicated the resident was admitted to the facility on 8/19/10 with diagnoses including, but not limited to, edema and Parkinson's disease. The resident's medications included, but were not limited to, furosemide 40 mg (milligrams) daily, a diuretic, which was started on 9/21/10 and potassium chloride 10 mg twice daily, which is routinely given along with furosemide due to the potassium wasting properties of furosemide. On 9/29/10, a laboratory test was completed for electrolytes which indicated the resident's electrolytes were within the reference range; the potassium was 3.7 (reference range, 3.6-5.1). Review of the physician's orders indicated there were no routine laboratory tests ordered to monitor the resident's electrolytes due to usage of furosemide. An interview with the Assistant Director of Nursing on 1/20/11 at 4:10 P.M., indicated the facility had contacted the resident's physician and were going to acquire an electrolytes laboratory test on 1/21/11. 3.1-48(a)(3)	F 329	therapy were checked to ensure that routine labs were ordered. The physician was notified for those residents without routine orders and orders were obtained and added to the treatment plan and their current plan of care. On 2/1/11, an inservice was provided to all licensed nursing staff by the Director of Nursing stating that all residents currently receiving - or new orders obtained for - diuretics should have labs drawn routinely, including, but not limited to electrolytes (Please see Attachment N-3-1, N-3-2, and N-3-3). All lab orders received were added to the treatment plan and the resident's current plan of care. It will be the responsibility of the Director of Nursing or her designee to monitor medication records to ensure that all procedures are followed according to the medication refusal policy and to ensure that medication refusals are included in the resident's written plan of care. This will be conducted through the facility's Quality Assurance Program. The Director of Nursing or designee will complete the Lab Review Q/A tool on ten percent (10%) of residents weekly for four (4) weeks, and then monthly thereafter to ensure ongoing compliance. Any identified trends will be logged on the Q/A Summary Log and reviewed in the monthly Q/A Meeting. The facility submits this information as credible allegations of compliance.	2/1/11 2/1/11 2/1/11